U.S. Consulate General

Consulate General of the United States of America
2 Walter Carrington Crescent, Victoria Island
Lagos, Nigeria
LagosIV@state.gov

Date: _____

FOR THE EXAMINING PHYSICIAN:

EACH FORM (DS-2053) SHOULD BE ENDORSED BY THE PANEL PHYSICIAN AS FOLLOWS:

I certify that the person covered by this report is the bearer of Passport No: _____
Issued by: _____ on _____.

Dear Sir:

You are requested to perform a medical examination of _____ in accordance with provisions of the "Technical Instructions for Medical Examination of Aliens" of the United States Public Health Service, which is in your possession, and to report the results on the attached Form DS-2053.

Please note that in accordance with Section 34.4 (pages 1-3) of the Technical Instructions cited above, neither a chest x-ray examination nor a serologic test for syphilis shall be required if the applicant is under the age of 15. A tuberculin test may be required, however, where there is evidence of contact with a known case of tuberculosis or other reason to suspect infection with tuberculosis. A serologic test may be required where there is reason to suspect infection with syphilis.

X-Ray for Pregnant Women

A postponement of the chest x-ray of a pregnant female is permissible; however, it is the position of the United States Public Health Service that it is possible to perform the examination safely during pregnancy with proper shielding of the abdomen. It should be explained to the applicant that if the x-ray examination were postponed, the issuance of the immigrant visa would also be postponed until such time as the medical examination is completed. U.S. Public Health Service regulations does not authorize a classification based only on a tuberculin skin test.

Procedure for Safeguarding Pregnant Women During X-Ray

The Bureau of Radiological Health, Food and Drug Administration and the Public Health Service have provided the following information:

"Non-abdominal examinations, when conducted with appropriate technique factors, collimation and abdominal shielding, contribute only negligible exposure to the embryo or fetus. (Collimation refers to adjustment by the operator of the size of the x-ray beam so that it is no larger than the film). With specific reference to ***chest x-rays***, we have calculated the estimated radiation dose to the embryo or fetus for each type of 14x17 film (AP, PA and lateral). With adequate collimation, a single PA film delivers 0.09 millirad (mrad) to the embryo or fetus which is essentially negligible. This assumes that the operator adequately collimates the x-ray beam. Further assurances of protection can be achieved by requiring that the abdominal area of the women be shielded with a lead apron."

Doubtful Cases

Whenever further medical consultation is deemed advisable, the visa applicant should be referred to an appropriate specialist at the applicant's expense. Under generally accepted medical procedures, the specialist should report his findings and opinion to the Panel Physician who remains responsible for the completion of Form DS-2053 and final results of the medical examination. In those comparatively rare instances where no specialist is available for consultations, the Panel Physician may refer specific problems to the Consulate General, which will in turn refer the case to the Public Health Service in the United States.

It is absolutely essential that any practitioner performing any part of this medical examination take proper care to identify the applicant by comparison with his photograph. Special attention should be given to ensure that specimens submitted by the applicant are from the applicant and not a third party.

FOR THE APPLICANT:

VISA MEDICAL EXAMINATION
Information Sheet and Referral Letter

1. A medical examination is required of all applicants for immigrant visas. **NO APPLICANT WILL BE INTERVIEWED PRIOR TO THE RECEIPT OF THE RESULTS OF THE MEDICAL EXAMINATION AND TESTS.**

2. **Approved Examiners:** Medical examinations must be performed by physicians designated by the Consulate General according to procedure prescribed by the U.S. law. The examining physicians are not employed by the U.S. Government.

3. **Fees:** Examination fees are paid by the applicant and are paid directly to the medical facility.

4. **Report of Examination:** The examining physician will either forward the completed report to the Consulate General or hand it to you in a sealed envelope for presentation to the Consular Officer. All sealed envelopes must be opened in the presence of the security guard or gate attendant before gaining entry to the Visa Section.

5. **Referral Procedure:** The following are the physicians and institutions by whom you must be examined. You only need to go to either location; no prior appointment is necessary. Please provide the examiners with two (2) copies of your passport photograph.

Dr. Alexandra Anga
Consultants/The Children's Practice
25 Raymond Njoku
Ikoyi
Lagos
Telephone: 01-893-0723

Dr. K. A. Omotosho
KAMORASS Specialist Clinics
238A Muri Okunola Street
Victoria Island
Lagos
Telephone: 01-461-2032

6. **Hours of Examination:** A minimum of three (3) working days must be allowed to complete the medical examination process. At times, the process may take longer than three days. Please note the following hours of examination:

Monday – Friday	**8:00 a.m. – 5:00 p.m.**
Saturdays	**9:00 a.m. – 2:00 p.m.**

Appointment times for the physical examination will be given during the first visit. The physical examination cannot be performed until the lab test results are available. Please also note that you will be required to appear on two (2) separate days – one day for x-rays and laboratory tests; and another day for examination and results.

HIV TESTING

Human Immunodeficiency Virus (HIV) testing is no longer required as of January 4, 2010. The Panel Physician may perform the HIV test if the applicant requests or consents to it, but must disclose to the applicant that the applicant does not have to be tested for HIV and that the results of the HIV test will be provided to the Consular Section as part of the visa medical examination. However, HIV applicants are no longer ineligible to receive a visa due to this condition.

Photo

U. S. Department of State

MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT

For use with TB Technical Instructions 1991 and the DS-3024

OMB No. 1405-0113
EXPIRATION DATE: 07/31/2013
ESTIMATED BURDEN: 10 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI.)* _____, _____, _____

Birth Date *(mm-dd-yyyy)* _____ **Sex:** ☐ M ☐ F

Birthplace *(City/Country)* _____ / _____

Present Country of Residence _____ **Prior Country** _____

U.S. Consul *(City/Country)* _____ / _____

Passport Number _____ **Alien** *(Case)* **Number** _____

Date *(mm-dd-yyyy)* **of Medical Exam** _____ **Date** *(mm-dd-yyyy)* **of Prior Exam, if any** _____

Date Exam Expires *(6 months from examination date, if Class A or TB condition exists, otherwise 12 months) (mm-dd-yyyy)* _____

Exam Place *(City/Country)* _____ / _____ **Panel Physician** *(name)* _____

Radiology Services *(name)* _____ **Screening Site** *(name)* _____

Lab *(name for syphilis/TB)* _____ / _____ / _____

(1) Classification *(check all boxes that apply):*

☐ **No apparent defect, disease, or disability** *(see Worksheets DS-3024, DS-3025 and DS-3026)*

☐ **Class A Conditions** *(From Past Medical History and Physical Examination Worksheets)*

- ☐ TB, active, infectious *(Class A, from Chest X-Ray Worksheet)*
- ☐ Syphilis, untreated
- ☐ Chancroid, untreated
- ☐ Gonorrhea, untreated
- ☐ Granuloma inguinale, untreated
- ☐ Lymphogranuloma venereum, untreated
- ☐ Hansen's disease, untreated multibacillary
- ☐ Addiction or abuse of specific* substance without harmful behavior
- ☐ Any physical or mental disorder (including other substance-related disorder) with harmful behavior or history of such behavior likely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

☐ **Class B Conditions** *(From Past Medical History and Physical Examination Worksheets)*

- ☐ TB, active, noninfectious *(Class B1, from Chest X-Ray Worksheet)*
  Treatment: ☐ None ☐ Partial ☐ Completed
- ☐ TB, inactive *(Class B2, from Chest X-Ray Worksheet)*
  Treatment: ☐ None ☐ Partial ☐ Completed
  See Section 4 on page 2 for TB treatment details
- ☐ Syphilis *(with residual deficit)*, treated within the last year
- ☐ Other sexually transmitted infections, treated within last year
- ☐ Current pregnancy, number of weeks pregnant _____
- ☐ Other *(specify or give details on checked conditions from worksheets)*
- ☐ Hansen's disease, treated multibacillary
  Treatment: ☐ Partial ☐ Completed
- ☐ Hansen's disease, paucibacillary
  Treatment: ☐ None ☐ Partial ☐ Completed
- ☐ Sustained, full remission of addiction or abuse of specific* substances
- ☐ Any physical or mental disorder (excluding addiction or abuse of specific* substance but including other substance-related disorder) without harmful behavior or history of such behavior unlikely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

_____

_____

_____

(2) Laboratory Findings *(check all boxes that apply):*

Syphilis: ☐ **Not done**

	Test name	Date(s) run *(mm-dd-yyyy)*	Negative	Positive	Titer 1	Notes
Screening			☐	☐		
Confirmatory			☐	☐		

Treated	If treated, therapy:	Date(s) treatment given *(3 doses for penicillin)*
☐ Yes	☐ Benzathine penicillin, 2.4 MU IM	
☐ No	☐ Other *(therapy, dose)*:E	

(3) **Immunizations** *(See Vaccination Form, check all boxes that apply)* **Not required for refugee applicants.**

☐ Vaccine history complete

☐ Vaccine history incomplete, requesting waiver *(indicate type below)*

☐ Incomplete vaccine history, no waiver requested

☐ Blanket waiver ☐ Individual waiver

I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.

Applicant Signature	Panel Physician Signature	Date *(mm-dd-yyyy)*

(4) **Tuberculosis Treatment Regimen**

(Fill out if applicant has taken in the past, or is now taking TB medication. If drug doses or dates not known or not available, mark "unknown".)

☐ Check if therapy currently prescribed *(if current, don't mark "End Date")*

Medication	Dose/Interval *(i.e., mg/day)*	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*
☐ Isonaizid (INH)			
☐ Rifampin			
☐ Pyrazinamide			
☐ Ethambutol			
☐ Streptomycin			
☐ Other, specify			

Applicant's pre-treatment weight (kg) _____ Date *(mm-dd-yyyy)* _____

Remarks _____

_____

_____

_____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

CONFIDENTIALITY STATEMENT

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PURPOSE: The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES: If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws.

U.S. Department of State

CHEST X-RAY AND CLASSIFICATION WORKSHEET

For use with TB TI 1991 and the DS-2053

Complete Sections 1 through 5, As Applicable

OMB No. 1405-0113
EXPIRATION DATE: 07/31/2013
ESTIMATED BURDEN: 10 MINUTES
(See Page 2 - Back of Form)

Name *(Last, First, MI.)*		Age
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien (Case) Number

1. Chest X-Ray Indication *(Mark all that apply)*

- ☐ History of Tuberculosis *(TB)* Disease
- ☐ Contact with Person with TB
- ☐ TB Signs or Symptoms
- ☐ Adult *(With or without any of the other indications)*

(If child does not have any of the above, stop here.)

2. Chest X-Ray Findings

Date Chest X-Ray Taken *(mm-dd-yyyy)* _____

- ☐ Normal Findings
- ☐ Abnormal Findings *(Indicate category and finding, checking all that apply, in the table below.)*

☐ **Can Suggest ACTIVE TB** *(Need smears)*	☐ **Can Suggest INACTIVE TB** *(Need smears if symptomatic)*	☐ **OTHER X-Ray Findings**
☐ Infiltrate or consolidation	☐ Discrete fibrotic scar or linear opacity *(fibrotic scar)*	☐ **Follow-Up Needed** *(Mark as "Class B Other")*
☐ Any cavitary lesion	☐ Discrete nodule*(s)* without calcification	☐ Musculoskeletal
☐ Nodule or mass with poorly defined margins *(such as tuberculoma)*	☐ Discrete linear opacity *(fibrotic scar)* with volume loss or retraction	☐ Cardiac
☐ Pleural effusion*	☐ Other *(Such as bronchiectasis)*	☐ Pulmonary, non-TB *(e.g., emphysema)*
☐ Hilar/mediastinal adenopathy with or without atelectasis		☐ Other
☐ Other *(Such as miliary findings)*		☐ **No Follow-Up Needed for** Pleural thickening, diaphragmatic tenting, calcified pulmonary nodule*(s)*, calcified lymph node*(s)*, calcified lymph nodes with calcified pulmonary nodule*(s)*, or minor musculoskeletal findings
* If unclear whether pleural fluid or thickening, perform lateral or decubitus chest radiograph, or targeted ultrasound.		

Remarks

Radiologist's Signature

Date Interpreted *(mm-dd-yyyy)*

3. Sputum Smears

☐ **No, Applicant has No Signs or Symptoms of TB and :**

- ☐ X-Ray Suggests INACTIVE TB, this is a **Class B2/TB**
- ☐ OTHER X-Ray Findings Suggest Follow-Up Needed after Arrival, this is **B Other**
- ☐ OTHER X-Ray Findings Suggest No **Follow-Up Needed,** this is **No Class**
- ☐ X-Ray Normal, this is **No Class**

☐ **Yes, Applicant has** *(Mark all that apply)* :

- ☐ Signs or Symptoms of TB, See Section 1
- ☐ X-Ray Suggests ACTIVE TB, See Section 2

and Smear Results are:

Positive	Negative	Dates Obtained *(mm-dd-yyyy)*
☐	☐	_____
☐	☐	_____
☐	☐	_____

Sputum Smear Results and X-Ray:
At least One Smear Result POSITIVE and

☐ Any Chest X-Ray Finding *(Normal or Abnormal findings)*, this is **Class A/TB**

Three Smear Results NEGATIVE and

- ☐ X-Ray Normal with
  - ☐ Signs or Symptoms Resolved, this is **No Class**
  - ☐ Signs or Symptoms Suggest Follow-Up Needed after Arrival, this is **B Other**
- ☐ X-Ray Suggests ACTIVE or INACTIVE TB, this is **Class B1/TB**
- ☐ OTHER X-Ray Findings Suggest Follow-Up Needed After Arrival, this is **Class B Other**

4. ☐ **No Class** ☐ **Class A/TB** ☐ **Class B1/TB** ☐ **Class B2/TB** ☐ **Class B Other**

5. Follow-Up Needed After Arrival ☐ No ☐ Yes If Yes, for ☐ Not TB Condition ☐ TB Condition

Remarks *(If non-TB condition, specify condition below **and** on DS-2053 form; include additional tests, and therapy used with start and stop dates and any changes. If TB condition, enter information in Part 4 of DS-2053 form.)*

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

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U.S. Department of State

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

For use with DS-2053 or DS-2054

OMB No. 1405-0113
EXPIRATION DATE: 07/31/2013
ESTIMATED BURDEN: 35 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien *(Case)* Number

1. Past Medical History *(indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)*
NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

No	Yes	
		General
☐	☐	Illness or injury requiring hospitalization *(including psychiatric)*
		Cardiology
☐	☐	Angina pectoris
☐	☐	Hypertension *(high blood pressure)*
☐	☐	Cardiac arrhythmia
☐	☐	Congenital heart disease
		Pulmonology
☐	☐	History of tobacco use Current use ☐ Yes ☐ No
☐	☐	Asthma
☐	☐	Chronic obstructive pulmonary disease *(emphysema)*
☐	☐	History of tuberculosis *(TB)* disease Treated ☐ Yes ☐ No Current TB symptoms ☐ Yes ☐ No
		Neurology and Psychiatry
☐	☐	History of stroke, with current impairment
☐	☐	Seizure disorder
☐	☐	Major impairment in learning, intelligence, self care, memory, or communication
☐	☐	Major mental disorder *(including major depression, bipolar disorder, schizophrenia, mental retardation)*
☐	☐	Use of drugs other than those required for medical reasons
☐	☐	Addiction or abuse of specific* substance *(drug)* *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
☐	☐	Other substance-related disorders *(including alcohol addiction or abuse)*
☐	☐	Ever taken action to end your life

No	Yes	
☐	☐	Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs
		Obstetrics and Sexually Transmitted Diseases
☐	☐	Pregnancy Fundal height _____ cm Last menstrual period Date *(mm-dd-yyyy)* _____
☐	☐	Sexually transmitted diseases, specify _____
		Endocrinology and Hematology
☐	☐	Diabetes mellitus
☐	☐	Thyroid disease
☐	☐	History of malaria
		Other
☐	☐	Malignancy, specify _____
☐	☐	Chronic renal disease
☐	☐	Chronic hepatitis or other chronic liver disease
☐	☐	Hansen's Disease ☐ Multibacillary ☐ Paucibacillary Treated ☐ Yes ☐ No
☐	☐	Visible disabilities *(including loss of arms or legs)*, specify
☐	☐	Other requiring treatment, specify

2. Physical Examination *(indicate findings and give details in Remarks)*

☐ No ☐ Yes Applicant appears to be providing unreliable or false information, specify

Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____

BP ____ /____ *(mmHg)* Heart rate _____ /min Respiratory rate _____ /min Corrected L 20/ _____ R 20/ _____

***N, normal; A, abnormal; ND, not done**

N*	A*	ND*	
☐	☐	☐	General appearance and nutritional status
☐	☐	☐	Hearing and ears
☐	☐	☐	Eyes
☐	☐	☐	Nose, mouth, and throat *(include dental)*
☐	☐	☐	Heart *(S1, S2, murmur, rub)*
☐	☐	☐	Breast
☐	☐	☐	Lungs
☐	☐	☐	Abdomen *(including liver, spleen)*
☐	☐	☐	Genitalia *(including circumcision, infection(s))*
☐	☐	☐	Inguinal region *(including adenopathy)*
☐	☐	☐	Extremities *(including pulses, edema)*
☐	☐	☐	Musculoskeletal system *(including gait)*
☐	☐	☐	Skin *(including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)*
☐	☐	☐	Lymph nodes
☐	☐	☐	Nervous system *(including nerve enlargement)*
☐	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)*

3. Additional Testing Needed Prior to Approving Medical Clearance

No	Yes	
☐	☐	Physical examination or laboratory results contradict medical history
☐	☐	Referral prior to departure If yes, provide results _____
☐	☐	Referral prior to departure If yes, provide results _____

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency *(Exception: For TB medications, use Part 4 of DS-2053 or DS-2054 form)* _____

☐ For continuing other treatment, specify _____

5. Remarks *(Describe any abnormal history, abnormal findings, and resulting interventions)*

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 35 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202.

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PURPOSE The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws.

U.S. Department of State

VACCINATION DOCUMENTATION WORKSHEET

For Use with DS-2053 or DS-2054 — To Be Completed by Panel Physician Only

OMB No. 1405-0113
EXPIRATION DATE: 07/31/2013
ESTIMATED BURDEN: 30 minutes
(See Page 2 of 2)

Name *(Last, First, MI.)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien (*Case*) Number

REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS

NOT REQUIRED FOR REFUGEE APPLICANTS

NOTE FOR PANEL PHYSICIANS:
For refugee applicants, please complete only if reliable vaccination documents are available.

1. Immunization Record

Vaccine	Vaccine History Transferred From a Written Record *(List Chronologically from Left to Right)* Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Vaccine Given by Panel Physician *(mm-dd-yyyy)*	Completed Series *(✓ if Completed, Write "VH" if Varicella History, or write Date of Lab Test if Immune)*	Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below: Not Age Appropriate	Insufficient Time Interval	Contra-indicated	Not Routinely Available	Not Fall *(Flu)* Season
Specify (*check*) vaccine: ☐ DT ☐ DTP ☐ DTaP											
Specify (*check*) vaccine: ☐ Td ☐ Tdap											
Specify (*check*) vaccine: ☐ Polio -OPV ☐ IPV											
Specify (*check*) vaccine: ☐ MMR (Measles-Mumps-Rubella) ☐ Rubella Specify (*check*) vaccine: ☐ Measles ☐ Measles - Rubella Specify (*check*) vaccine: ☐ Mumps ☐ Mumps - Rubella											
Rotavirus											
Hib											
Hepatitis A											
Hepatitis B											
Meningococcal											
Human papillomavirus											
Varicella											
Zoster											
Pneumococcal											
Influenza											

2. Results

☐ Vaccine History Incomplete

- ☐ Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate *(as Indicated Above)*.
- ☐ Applicant will request an individual waiver based on religious or moral convictions.

☐ Vaccine history complete for each vaccine, all requirements met *(Documented Above)*.

☐ Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.

3. Panel Physician *(Name)* _____

Panel Physician *(Signature)* _____

Date *(mm-dd-yyyy)* _____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

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AUTHORITIES: The information asked for on this form is requested pursuant to Section 212(a) and 221(d) and as required by Section 222 of the Immigration and Nationality Act. Section 222(f) provides that the records of the Department of States and of diplomatic and consular offices of the United States pertaining to the issuance and refusal of visas or permits to enter the United States shall be considered confidential and shall be used only for the formulation, amendment, administration, or enforcement of the immigration, nationality, and other laws of the United States. Certified copies of such records may be made available to a court provided the court certifies that the information contained in such records is needed in a case pending before the court.

PURPOSE: The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES: If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws.